PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ ❑ Male ❑ Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

State ID/Driver's License #: _____ E-mail Address: _____

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	❑	❑	Excessive Bleeding	❑	❑	Jaundice	❑	❑	Respiratory Problems/Disorders	❑	❑
Alcoholism	❑	❑	Epilepsy	❑	❑	Kidney Disease	❑	❑	Rheumatic Fever	❑	❑
Allergies	❑	❑	Glaucoma	❑	❑	Kidney Dialysis	❑	❑	Rheumatism	❑	❑
Anemia	❑	❑	Hay fever	❑	❑	Latex Sensitivity	❑	❑	Scarlet Fever	❑	❑
Arthritis	❑	❑	Head injuries	❑	❑	Lupus	❑	❑	Seizures/Fainting spells	❑	❑
Asthma	❑	❑	Hearing Impaired	❑	❑	Low Blood Pressure	❑	❑	Sinus Problems	❑	❑
Blood Disease	❑	❑	Heart Disease	❑	❑	Malignancies	❑	❑	Stomach Ulcers	❑	❑
Bone Disease	❑	❑	Heart Valve, Murmur	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke	❑	❑
Cancer	❑	❑	Hepatitis/Liver Disease	❑	❑	Neck & Back Problems	❑	❑	Thyroid Disease	❑	❑
Chemical Dependency	❑	❑	Type(s) _____			Nervous Problems/Disorders	❑	❑	Tuberculosis	❑	❑
Chest Pain	❑	❑	Hepatitis Carrier	❑	❑	Pacemaker	❑	❑	Tumors or growths	❑	❑
Circulatory Problems	❑	❑	High Blood Pressure	❑	❑	Prosthetic Joints	❑	❑	Ulcers	❑	❑
Convulsions/Seizures	❑	❑	Hip or Joint replacement	❑	❑	Psychiatric Care	❑	❑	Venereal Disease	❑	❑
Diabetes	❑	❑	HPV	❑	❑	Radiation Treatment	❑	❑			

Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

_____

Are you allergic to any medications? ❑ YES ❑ No If yes, please list below:

_____

_____

Are you in good health? ❑ YES ❑ No

Date of last medical exam: _____

Have you ever been hospitalized? ❑ YES ❑ No If yes, what was the problem

_____

_____

Do you have any disease/problem you think we should know about? ❑ YES ❑ No

_____

_____

_____

_____

Have you had a transplant operation that has depressed your immune system? ❑ YES ❑ No

Have you had an allergic reaction to Bananas? ❑ YES ❑ No

Do you smoke or chew tobacco? ❑ YES ❑ No

Have you had Heart Surgery? ❑ YES ❑ No

Are you now under the care of an MD? ❑ YES ❑ No

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc) ❑ YES ❑ No

FOR WOMEN ONLY:

Are you taking birth control pills? ❑ YES ❑ No

Are you nursing/breastfeeding? ❑ YES ❑ No

Are you pregnant? ❑ YES ❑ No Expected delivery date: _____

Is there a possibility of pregnancy? ❑ YES ❑ No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Date: _____

Dental History Information

Date of last dental visit? _____

Name of your previous dentist _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ❑ YES ❑ No

How often do you floss your teeth? _____

Dr. Signature: _____

Do your gums bleed when you brush? ❑ YES ❑ No

Have you or a family member ever been treated for periodontal disease? ❑ YES ❑ No

Have you ever had complications from an extraction? ❑ YES ❑ No

Have you ever had a popping or clicking near your ear when you chew? ❑ YES ❑ No

Are you prone to frequent headaches? ❑ YES ❑ No

Do you grind or clench your teeth? ❑ YES ❑ No

Date: _____

Do you have sores, blisters or swelling on your gums lips or cheeks? ❑ YES ❑ No

Have you ever had orthodontic treatment? ❑ YES ❑ No

Do you snore? ❑ YES ❑ No

Do you have problems with bad breath? ❑ YES ❑ No

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? ❑ YES ❑ No

Have you ever used an electric toothbrush? ❑ YES ❑ No

Are your teeth sensitive to hot, cold or pressure? ❑ YES ❑ No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be:

- ❑ Whiter
- ❑ Straighter
- ❑ Close Space
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Less gums showing
- ❑ Replace old crowns or caps that don't match

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Reviewed by: _____

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

AUBURN HILLS
FAMILY DENTISTRY

Financial Policy

Thank you for choosing Auburn Hills Family Dentistry as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. It is customary for us to receive full payment at the time of service; patients with dental insurance are required to pay their estimated co-pays and deductibles at the time of service. When extensive treatment is planned requiring many appointments, we realize it may be necessary to make other arrangements. We have the following options available to you:

For Patients without Dental Insurance Coverage

- Payment in full at each appointment as the treatment is provided. We accept cash, check, Visa, Mastercard, Discover, American Express and CareCredit®.
- A payment plan dividing the cost into equal payments corresponding to the number of visits necessary to complete the individual procedures. This option MUST be approved by the Doctor and/or Office Manager.

For Patients with Dental Insurance Coverage

- PLEASE BE AWARE: Insurance does NOT cover the entire fee of most services! The amount of coverage provided is decided between your employer and your insurance company and is out of our control. PLEASE NOTE: It is the patient's responsibility to know their insurance coverage and any changes that may occur.
- We ask for payment of whatever percent the insurance does not cover of the cost for each service at the time it is rendered. We will complete and send whatever pre-treatment or estimation information that may be required, and we will send your insurance forms in for payment as each phase of treatment is performed. We will await the insurance check if they make payment within sixty days. If payment from your insurance company is not paid within this time, you will be responsible for the balance owed and can await the insurance company payment. We will be happy to provide you with any documentation needed to collect reimbursement directly from your insurance company.

At Auburn Hills Family Dentistry we strive to provide you with the best treatment for you and your family. This is not the case for insurance companies. This is an important thing to remember when we recommend treatment that is in your best interest but may not be covered by your insurance plan.

Thank you for your cooperation.

Our Office Manager and Receptionist are responsible for scheduling your appointments and completing your financial arrangement. They will sincerely consider your needs in each of these areas. If you should have any questions regarding the above mentioned options, please do not hesitate to consult with them.

I have read and understand the financial policy:

Signature of patient, parent, or guardian: _____ Date: _____

1862 Auburn Rd Suite 103
Dacula, Ga 30019

AUBURN HILLS
FAMILY DENTISTRY

Consent for Services

I _____ hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary (including nitrous oxide). I fully understand that using such anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand and agree that I am responsible for any portion of my bill that my insurance company does not pay within sixty days of claim submission. I understand payment is due at the time of service.

If this account must be turned over to collections, then you would be responsible for all collection fees charged by the agency.

Signature of Patient, or Guardian: _____ Date:_____

Relation to Patient: _____

Acknowledgement of Receipt of Privacy Practices and HIPPA Statement.

I have received a copy of the Notice of Privacy Practices and a copy of the HIPPA statement for the above named practice.

Signature of Patient, or Guardian: _____ Date: _____

Relation to Patient: _____

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Dacula, Ga 30019

AUBURN HILLS
FAMILY DENTISTRY

Insurance Authorization

I authorize release of information to all my insurance carriers

I understand that I am responsible for treatment not paid by my insurance within 60 days after claim submission.

I authorize payment directly to my doctor

I authorize my doctor to act as my agent in helping me obtain payment from my insurance

We reserve your appointment time on our schedule. We ask your consideration in keeping your Appointments. If you must miss your appointment, please call 24 in advance so that we may be able to fill that time slot with another patient. If you miss or cancel 2 appointments without giving proper notice we reserve the right to dismiss you from our practice.

Signature of Patient, or Guardian: _____ Date:_____

Relation to Patient:_____

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